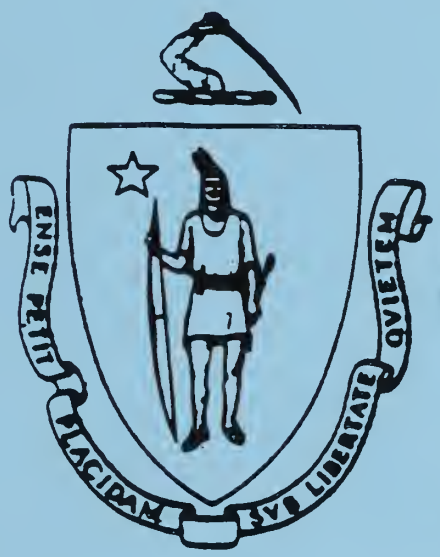
COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Department of Mental Health
Marylou Sudders, Commissioner



THE DMH CORE CURRICULUM

Office of Clinical and Professional Services
The Training Program
January 1997

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COMMONWEALTH OF MASSACHUSETTS
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THE UNIQUE MENTAL HEALTH NEEDS OF THE ELDERLY

January, 1997

Office of Clinical and Professional Services
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INTRODUCTION TO THE SERIES

This is an era of exciting challenges in healthcare. The Department of Mental Health is in the forefront of these changes with new initiatives in managed care, privatization, and comprehensive community support systems.

To ensure the highest quality of care during this period of change, the Commissioner instructed that a DMH Core Curriculum be drawn up, and that within a three-to-five year period that every DMH state and provider employee be instructed in the components of this curriculum. With the full support of the Deputy Commissioners and the Area Directors, DMH state and provider managers and staff, and consumers and family members developed the Core Curriculum in the Summer and Fall of 1992.

Since many agencies already provide instruction in various aspects of the Core, a state-wide needs assessment was completed in the Summer and Fall of 1992 to determine which components of the Core needed more immediate attention. Again, DMH state and provider agencies, consumers and families participated. Eight areas were identified as needing more precise clinical practice guidelines: the role of the consumer, human rights, the role of the family, dual diagnosis (mentally ill/chemically addicted), alternatives to restraint and seclusion, psychosocial rehabilitation, multicultural issues, and gerontology.

In the Fall of 1992, Clinical Practice Guidelines Workgroups for these eight areas were convened. Consumers, families, and DMH state and provider employees participated in developing these practice guidelines. Each group was asked to develop the basic guidelines for practice in its area, to write a training manual on that topic, and to outline a training for its area of expertise.

This manual, the previous manuals, and those to follow present the DMH clinical practice guidelines for the basic components of the Core Curriculum. It is hoped and expected that each DMH state and provider agency will incorporate these guidelines in practice so that every DMH consumer can expect a reasonable and consistent standard of care in any community in the Commonwealth.

Paul J. Barreira, M.D.
Deputy Commissioner, Clinical and Professional Services

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Director of Training

January, 1997

DMH Core Curriculum
THE UNIQUE MENTAL HEALTH NEEDS OF THE ELDERLY

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The Elder Mental Health Subcommittee of the
Massachusetts Health Planning Council

Commonwealth of Massachusetts
Department of Mental Health

Core Curriculum: The Unique Mental Health Needs of the Elderly

Many thanks to the following people for their contributions to the development of this core training curriculum: Marta Frank, Chair of the committee, for planning and organizing the development of the curriculum, and to Walter Polesky and Patricia Vancil for curriculum planning and for establishing this project as a joint effort of the Massachusetts Department of Mental Health and the Massachusetts Department of Public Health.

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THE UNIQUE MENTAL HEALTH NEEDS OF THE ELDERLY

INTRODUCTION

By the year 2000 almost 35 million people living in the United States will be age 65 or older. Of these about 7.5 million will need help with mental health problems.(1) The most common mental illnesses affecting elders are depression, dementia, including Alzheimer's Disease, delirium, substance abuse, and chronic mental illness such as schizophrenia. Some of these illnesses may be of acute onset, while others are chronic and long-standing. Elders may have been able to hide or compensate for a problem, but for various reasons are no longer able to do so. Complicating this situation is the common problem of misdiagnosis and inappropriate treatment. Older people may not seek help for emotional and mental distress because they may feel embarrassed talking about their problems or fear that such disclosure may put them in a nursing home or psychiatric facility. If they do seek help they usually approach a family physician who may or may not make an appropriate referral.

Geriatric psychiatry is a growing field which involves the interplay of medical, psychological, and social health. As we learn more about the area of geriatric mental health we are able to determine the different needs of elders from their younger counterparts. Although both groups may, for example, present with symptoms of depression, in some ways they need to be approached differently. Sensitivity and awareness of the concerns of older people about seeking treatment will help facilitate a smoother process of intake, assessment, and care.

SECTION ONE: AGING

"Age" - to live a long time, mature. What does it mean to age, to grow old? Aging implies growth, for to grow old means to have lived a long time. Aging is hard to define, for it has many cultural contexts and meanings as well as definable biological processes. To grow old is to gain in life experience, yet to slow down in bodily function. We are ambivalent about aging, for it is both a loss and a gain, an accumulation of experience and wisdom, yet a time of decline as well. Even though we as a society have made many technological advancements, we have not been able to stop or control the aging process nor have we extended the possible human life span in any significant way. For all of the advances made to preserve health, the outside limit of life is still about 120 years, as it has been in all recorded history.

There is no such thing as a "typical" older person, nor is there an elderly personality type or set of psychological characteristics. It is a well known fact that we age as we live: the good-natured younger person is a good-natured older person, the cantankerous older person was probably crabby as a young adult, too. Illness and medication may affect personality, but aging, by itself, does not.

Old age in our society means transition and change. As people age they may:

Retire from paid work, become volunteers, become widowed, possibly remarry, become grandparents and great-grandparents, relocate to smaller housing or to other parts of the country, become caretakers for ill family members or for grandchildren, deal with reduced finances, become ill themselves.

Some people seem to manage the transitions of old age better than others. Although research into healthy aging is scant, resiliency theories may help us discern the characteristics of a healthy old age.(2)

The following factors may help increase chances for a positive adjustment to old age:

Optimism.
Connection to other people.
Membership in religious, civic, social groups or organizations.
Adaptability and flexibility: the ability to manage transitions well.
The ability to recover well from loss.
A healthy lifestyle: proper diet, exercise, recreation.
Spirituality.
Sense of humor.

Other factors may contribute to a more difficult adjustment old age, such as:

Social isolation.
Use of alcohol and other drugs.
History of depression and other disabling illness.
Inability to adapt well to loss and change.

The developmental tasks of normal aging include making sense of and attaching meaning to one's life, and sharing these perceptions with others. The ways in which these tasks take place also affect the ability of a person to age with dignity and self-respect.

However people may deal with the social transitions of aging, certain **cognitive changes** seem almost (but not always) inevitable. These may include changes of:

Memory. Long term memory is usually not affected by normal aging, but the ability to retrieve short-term memory and recall is often reduced. For example, many people have greater difficulty remembering names and phone numbers as they age, and may need more time to remember past events.

Intelligence Older people do not lose intelligence although small changes may occur. For example, elders may take a longer time to complete a mental status exam, yet may have increased perspective and wisdom due to accumulated life experience. Older people have stable reasoning and information-keeping capacities, but small changes in abstract thinking and language can take place after the age of 70.(3)

It is therefore important to note that older people may fear dementia or question their own mental capacities, resulting in a loss of self-esteem, and that older people may be over-diagnosed with dementia.

Biological changes as we age

The aging process slows us down. As people age their reaction time is slower, they tend to digest more slowly, and they take longer to metabolize medication, alcohol and other drugs. Although this may cause some concern for elders and their families, this slowing down is not necessarily a diseased state that needs to be fixed. The concern, rather, is to distinguish healthy aging from disease. A vigorous old age can be filled with activity and energy but can also take place at a normally slower pace.

Since older people react differently to medications, their use of all medications including over-the-counter drugs, and alcohol, needs to be periodically reviewed and discussed. Review medications before assessing for illness or disease.

The following **common medical conditions** may affect the mental health and life functioning of older adults:

Hearing loss affects about 30% of people over the age of 65, resulting in difficulty hearing high tones, or possibility ringing in the ears (tinnitis).

Vision impairment affects about 10% of the older population, including the effects of cataracts and glaucoma.

Arthritis affects up to 50% of older adults, resulting in fatigue, joint pain, and reduced mobility.

Osteoporosis affects one out of every three women over the age of 65 and at least one out of every ten men age 65 and

older, resulting in fragile bones, reduced mobility, and pain.

Functional changes of aging:

Due to the above biological changes, normal older adults may have difficulty with:

> Driving a car, walking, performing household chores, doing personal errands like food shopping, social visiting, reading, listening to radio or music.

These biological and functional difficulties can often be alleviated or coped with through concrete and supportive adaptive aids and social services. They should not be assumed to be inevitable by either older people or providers.

Older adults have encountered life situations that may have affected their capacity for coping and/or given them a broader life perspective.

Many Older People:

- Have adjusted to many social and cultural changes in their lives.
- Have lived through wars, epidemics, and personal and social disasters.
- Have held a variety of social roles such as parent, spouse, partner, worker, neighbor, volunteer.
- May be gay or lesbian.
- Have lived through major economic crises, such as the Great Depression in the United States.
- May have immigrated to this country.
- May have experienced family or social trauma as a child.
- Have adapted to the many social, technological and cultural changes in the 20th century.
- Have a rich personal history.

SECTION TWO: WORKING WITH OLDER PEOPLE EXPERIENCING MENTAL HEALTH PROBLEMS

Increasing Access to Treatment: Guidelines for Making Your Program More User-Friendly

The following suggestions may help decrease barriers to service for elders and their families, and increase the likelihood of effectively serving elder needs.

1. Make concrete changes in your facility. Look around your agency. What is it about the physical plant that seems welcoming to elders? Is it set up for elder access? Does it have wheelchairs available, ramps, wide doorways, rails on stairs. Are there canes available? Is it well-lit? Do you have any posters, literature, books and pamphlets on issues related to elder health? Are these available for elders to read in the waiting room? Ask elders for their suggestions. Consider making small but concrete changes that help elders feel that the service is there for them.

2. Train staff to more effectively communicate with elders. Examples of effective communication skills: take time; be patient; don't talk down or infantilize elders; don't assume they know nothing about mental health issues, but explain thoroughly when necessary; to minimize embarrassment try to universalize issues so people do not think their problems are solely the result of old age; talk directly to the elder even if someone else in also present; be respectful, using last names until you determine what they prefer to be called; be sensitive to people's fear of or concern with authority, especially if they come from cultures where authority figures were dangerous and threatening, and try to help elders maintain autonomy and personal dignity as much as possible.

3. Arrange for ways for elders with hearing loss to better hear and communicate. Have TTY telephone access and other amplification devices available for therapy sessions. Ask about the hearing and take a history; inquire about hearing aides and other enhancement devices; have hearing aid batteries on hand; meet in a quiet place free from background noise; speak clearly, facing the person; use nonverbal cues as much as is normally possible; check for understanding; openly discuss the hearing loss and urge the person to get assistance. Note: speaking at a slower, but natural, speed and with clear diction is usually more helpful than talking louder.

4. Overcome barriers that visual impairment may present. Ask elders about their eyesight; meet in a well-lit room; talk clearly and check for understanding; use large-print, high-contrast handouts; have access to magnifying and also reading glasses; explain and describe where you are and what you are

doing; openly discuss the vision problem and make a referral to an eye clinic or ophthalmologist. Include eye exams on each total work-up.

5. Increase elders' capacity to use transportation to the program. Know the public transportation system and be prepared to offer reasonable advice for safe and low-cost transportation. Have cab vouchers and bus schedules available; enlist the aid of family members; find out about other public means of transportation such as The Ride or services provided by the referent agency.

6. Train staff on the subtle but pervasive effects of cultural and institutional ageism that can prevent them from seeing elders realistically.

7. Counter internalized negative attitudes about aging on the part of elders through your own attitude. It is important to support and reinforce the strengths of the elder. Help the elder to reduce feelings of uselessness due to ageist assumptions about his or her capacity to change. Challenge him or her to take action.

8. Many older people believe that seeking help for emotional problems is a weakness. Work together with the elder to strengthen coping skills and develop an optimal treatment plan. Convey your attitude of the benefits of seeking and receiving help; universalize their situation ("lots of people..."); key into physical problems, which may be more acceptable and may provide a link to emotional disturbance; be matter-of-fact, and convey hope and encouragement for improvement.

9. Train staff to be culturally sensitive and encourage referrals to culturally appropriate programs. It is important that staff are sensitive to how they may appear as authority figures to people who are here as refugees or illegal aliens. Encourage hiring of staff who reflect the community they serve.

10. If elders and their families speak languages other than English, provide translators. Try not to rely on family members if possible, especially younger children. Provide literature in appropriate languages.

SECTION THREE: SUDDEN CHANGES IN MENTAL STATUS: GUIDELINES FOR AN EFFECTIVE ASSESSMENT

Older people need to be assessed in order to ascertain the reasons for a change in their mental status. An assessment collects information about the health condition of the elder and determines if more in-depth investigation of specific problems areas is needed.

1. Goals of assessment: to determine whether an adequate and complete assessment of the person has been conducted, and to recommend what assessments, if any, need to be made in order to make an effective referral.

2. Tools for assessment: medical chart; self-report by the older person; report by family, friends, landlady or other involved significants; records of other providers; possible home visit, and consideration of social and community supports.

Checklist: To ensure optimal care, it is important to collect the following information.

1. Complete medical history.

a. List of present and previous illness, including minor as well as major illness; family medical history.
b. Cognitive: changes in memory, perception, intelligence, orientation
c. Functional: mobility, personal hygiene, hearing, vision, activities of daily life.

2. Complete record of medication use.

a. Prescription drugs: how used, what combinations, compliance, expiration dates, borrowing medications from other people, substitution of generic drugs due to cost, patient's and family's report of effects of the medications.
b. Over-the-counter medications: what, how often, if substituted for prescription drugs, what combination, reports of effects on patient.
c. Use of alcohol, caffeine, tobacco, illicit drugs: patterns of use, effects on patient.
d. Use of nontraditional medicines and drugs: ethnic, experimental, alternative medications and their effects on patient and family.
e. Use of vitamins and energy supplements, and their effects.

3. Personal and social history.

a. Changes in family and social relationships; participation in groups or organizations; living situation; social visits with other people; telephone use; pets; volunteer activities.
b. Look for: changes in social roles, relationships and responsibilities, levels of stress for patient and family.
c. Consider safety issues: how safe is the patient; is the person vulnerable to crime, falls, and other injuries, or to abuse or neglect.

4. Mental Status

a. Has a Mental Status Exam been done or should another one be conducted. Pay attention to orientation, perception and memory to screen for dementia.

5. Psychiatric history

a. How complete is the history and does it need to be updated. Use elder's self-report as well as family history or other related information.

6. Primary care provider

a. If possible work with this person to obtain a complete medical, social, and psychiatric picture.

Special considerations of Medical Conditions:

It is important to include the following factors in the assessment, for any one of these can have significant influence on the older person's health.(4)

1. Stroke symptoms are similar to Alzheimer's Disease, but are not the same. Strokes have a sudden onset of symptoms. Mini-strokes can go undetected by the elder and his or her family.
2. Brain injuries like a blow or fall can cause pressure in the brain which looks like dementia.
3. Domestic violence, abuse or neglect can cause agitation, fear, anxiety, paranoia and even disorientation.
4. Arthritis often brings with it fatigue and depression not only as a response to the illness but also as a side-effect.
5. Endocrine disturbances. Thyroid problems may appear as symptoms of depression or Alzheimer's Disease, but can be easily treated.
6. HIV infection can cause brain tumors and other problems resulting in dementia, paranoia and disorientation.
7. Past history of trauma, may increase anxiety and paranoia.

8. Infections like urinary tract or certain respiratory infections can cause mental confusion.
9. Malnutrition, resulting in vitamin deficiency such as vitamin E or B Complex can cause mental confusion and listlessness.
10. Dehydration can cause disorientation. Many older people do not drink enough fluids because they feel less thirsty and are trying to avoid frequent urination.
11. Syphilis can cause behavioral and cognitive problems, but can be treated in its earlier stages.
12. Metabolic disturbances can affect attention span and cause depression and tremors. For example, hypoglycemia can cause dizziness and confusion.
13. The use of alcohol, even occasionally, can affect mood and sleep and should be noted along with these other considerations. Alcohol withdrawal can cause hallucinations and delirium.
14. Alcohol used in combination with many medications can also cause serious side effects.

If it is felt that the older person needs a more in-depth assessment, the following may prove helpful:

1. Contact a geriatrician for an medical assessment.
2. Pay attention to the interplay of medical, social and psychological histories.
3. Make sure to screen for organic mental illness.
4. Include questions about medication use as a major part of the assessment process.
5. It is important also to include information about the social functioning of the person and his or her family, if possible. Aim for the goal of total health and well-being.

SECTION FOUR: COMMON MENTAL HEALTH DIAGNOSTIC CATEGORIES

I. DEPRESSION

Depression is a major mental health problem confronting older people and their families. Elders suffer from depressive illness such as major depression and dysthymia as well as experiencing depressive symptoms.

Diagnosing Depression
Older people may share similar symptoms of depression with younger people, but elder depression can also differ in subtle but significant ways. Depression is often misdiagnosed in elders because it can mask as physical illness, dementia, or be attributed to the problems of old age. It is a well-known fact that older people often do not report feeling depressed, and if they do seek help will

usually approach their family doctor. Accurate diagnosis is also important because elders run a high risk of suicide. Men over the age of 75, for example, are at much higher risk for suicide than the rest of United States population. Quality of life is also a concern, for elders can live in depressed states for years without attention, resulting in a lost sense of well-being and compromised relationships with friends and family.

Loss and bereavement may affect memory and mood, and may increase anxiety and worry. A loss of a spouse will affect the elder in many ways: social role, intimacy, financial status, perhaps housing, sexuality, daily life. Major losses, both recent and unresolved, can result in at least temporarily compromising functioning and behavior.

Learning to identify the signs and symptoms of depression can help to determine a clear diagnosis and treatment plan. A common symptom is a tendency to complain of physical ailments, which may cause a provider to focus on physical illness and so miss the depression. At other times the older depressed person may appear to be disoriented, causing the provider to consider problems of dementia rather than depression. The following list of signs and symptoms may help to sharpen the identification of depression among elders.

Signs and Symptoms of Depression

- Vague physical complaints.
- Fatigue, low energy.
- Headaches, dizziness.
- Change in sleeping, eating patterns, trouble with digestion.
- Feelings of guilt, hopelessness.
- Feeling helpless and dependent on others.
- Thoughts of death, perhaps suicide.
- Trouble with memory and concentration.
- Loss of interest in caring for self and others.
- Feeling sad, tearful.
- Loss of interest in the activities and pleasures of daily life.
- Irritability.
- Increase in internalized ageism: feeling useless and unwanted.

These symptoms can easily be confused with metabolic disorders, stroke and other vascular problems, bereavement, alcohol and other drug problems, and dementia, so a clear differential diagnosis is warranted. Some of these problems may also coexist with clinical depression, but the depression must also be identified and treated for the older person to recover and regain a healthy quality of life.

Possible Treatment Considerations

1. Explore with the elder and his or her family any thoughts or intentions of suicide or other self-harm.
2. Consider any medical conditions that may affect choice of treatment. Develop a treatment plan that addresses the causes as well as the symptoms of the depression.
3. Continued support for the older person and his or her family may help to encourage compliance and also trouble-shoot any problems the person may have accessing treatment. Symptoms of apathy and helplessness can lead to discontinuation of treatment, so encouragement is important.

Possible Treatment Interventions

1. Psychotherapy and supportive counseling. Individual, family and/or group counseling can help the person learn strategies for coping with the symptoms of depression.
2. Somatic therapies are effective if preceded by a thorough medical assessment. A variety of medications are available, and finding the right combination may take some time.
3. E.C.T. is an effective treatment for elderly depression, and carries with it few side effects.
4. Alleviating social isolation and promoting involvement in activities can reduce symptoms of depression. Providing additional home care services may also be effective. See Section Five for more information.

II. DEMENTIA

Dementia is defined as cognitive, or intellectual, deterioration of the brain which affects memory and usually causes behavioral and functional changes. Although there is little effect on consciousness, the elder may or may not be aware of the dementia. The onset of dementia is often slow, subtle, and insidious.

The most frequent cause of dementia is Alzheimer's Disease, which is permanent and progressive. Other irreversible dementia can be caused by a number of illnesses including Pick's Disease, Parkinson's Disease, Huntington's Disease, chronic alcoholism, and some permanent brain tumors caused by HIV infection and cancer.

Some dementias are reversible or arrestible. These may be caused by mis-use or overprescription of medication; alcoholism; some viral, bacterial or fungal infections; some metabolic disorders and nutritional disorders; vascular problems such as hypertension; brain lesions or benign tumors; normal pressure hydrocephalus, and some affective disorders such as depression.

Signs and Symptoms
Since dementia has a slow and insidious onset, look for patterns, clusters and deterioration in the following examples of symptoms. Keep in mind specific cognitive and functional changes. Make sure to check with family members or friends, because the elder's self-reporting may, obviously, not be accurate. The following are common symptoms of dementia:

* Memory loss.
* Becoming lost or confused in familiar places.
* Trouble driving.
* Trouble remembering how to get to familiar places.
* Difficulty remembering uses for familiar tools and items.
* Change in judgment.
* Personality change - may become irritable, hostile, moody and tearful, suspicious and/ or paranoid.
* Deterioration of abstract thinking.
* Difficulty caring for self: dressing, grooming, personal hygiene.
* Difficulty managing finances and household tasks.
* Becoming disoriented and agitated.

Possible Treatment Interventions
Begin with an initial assessment (see Section Three). Include family history and a detailed, chronological account of the symptoms as reported by the older person and family members. Assessment tests are helpful but must be used in combination with other screening tools. Do not rely on a mental status alone to determine dementia.

Dementia may exist with other illness too. Determine the primary and secondary causes and their effects on function and cognition. For example, alcohol and/or medication use can cause dementia, and so alleviating these problems can also reduce dementia. An older person with a history of schizophrenia may develop dementia due to other illness. The dementia may in turn affect the psychosis in such a way that the psychosis needs to be treated differently.

Identify and treat all causes of the dementia. If the dementia still remains, then focus on retaining cognition, social relationships and functioning, and include support for family members as well. A key issue in treating dementia is also protecting the person and making sure he or she is safe.

II. A. Alzheimer's Disease

Alzheimer's Disease is the most common cause of dementia in older people. Approximately four million individuals in the United States have Alzheimer's, including over 100,000 in Massachusetts. The disease strikes about 10% of people over the age of 65, and about 47% of those over 85. Of those affected by Alzheimer's Disease, about 70-80% live in their communities, and most families do not receive any kind of financial assistance to help cope with the disease.(5)

Alzheimer's Disease is progressive, irreversible and degenerative. The disease develops slowly, beginning with mild forgetfulness and an inability to recall recent events, places and people. As the disease progresses people lose their sense of time and location, and forget all that is familiar to them, including their own names. People with Alzheimer's seem prone to wander, causing concerns to family members and other caregivers. Patients become incontinent and cannot care for themselves. Along with these symptoms patients also often experience fear, anxiety, paranoia, disturbance in sleep cycles, and can become irritable and angry much of the time. Delusions and hallucinations can also occur. The illness can last from 1 to 20 years, with 4 - 8 years being about average. Patients may die from a variety of other illnesses, most commonly pneumonia.

Diagnosis of Alzheimer's Disease

Accurate diagnosis is important in order to rule out other medical problems and other forms of dementia. More accurate diagnosis of Alzheimer's Disease can now be achieved through such tests as the CT-Scan and MRI, but a definitive diagnosis, using a brain tissue autopsy, cannot be made until after the patient's death.(6)

Since most people with AD also have more than 3 co-existing medical problems such as hypertension, hearing loss, cardiac problems and arthritis, careful planning must be made to care for the AD patient effectively. Patients also may have other illnesses such as depression and/or alcohol and other drug problems which also need to be addressed. (7)

Treatment planning issues for the older person with Alzheimer's Disease:

1. Have all other possible causes for the dementia been explored?
2. Will other co-existing problems such as high blood pressure, depression, or alcohol abuse be effectively addressed?
3. Is the patient and family connected with reliable medical resources? Do they know their rights as consumers?

4. Who will care for the patient? Caregivers of people with AD are at risk themselves for depression, overuse of medications and alcohol, hypertension, and other problems. How will caregivers receive the support they need?
5. Is the living environment safe for both patient and caregiver? What arrangements can be made to plan for possible behaviors like wandering, which could put the patient at risk for criminal assault or robbery?
6. Are there ways that families can sustain social supports and not become isolated?
7. Are strategies and resources available for patient and caregivers to maintain good health, for example, adequate health care, proper nutrition, exercise, etc. ?
8. Does the patient and family have access to useful literature about Alzheimer's Disease that educates them both about the disease and how to cope ?
9. Do caregivers know about organizations and support groups that give advice about coping and also serve to advocate for better services and for continued research into Alzheimer's Disease?
10. Is there adequate follow-up in place for both patient and caregivers in case plans need to be readjusted? For example, when institutionalized placement may be necessary.

A hopeful note:
Although AD is progressive and irreversible, many intervention strategies can make the course of the disease less stressful for family, patient, and other caregivers. Environmental manipulation and deeper understanding of why the patient is reacting the way she or he does can help to maintain quality of life for all concerned. Family members also need continued support as they navigate themselves and the patient through the course of disease.

The Alzheimer's Association recommends the following communication skills for working with Alzheimer's patients (8):

Speak at eye level with the patient. Establish eye contact as quickly as possible and maintain a comfortable distance between you and the patient. Speak slowly and in a low tone if possible. AD does not affect hearing so there is no need to use a loud tone of voice. Use a few words rather than a complicated sentence. Check with family members for words that are most familiar and for a sense of the person's personal vocabulary. Talk in a quiet place if you are giving the patient an important message.

Reassure the person as much as possible. A gentle touch or hug shows concern for him even if he does not understand you. If you do not understand him, say so, reassure him, and then try again in a little while. If understanding is difficult try to get in touch with his feelings and respond to the emotion rather than the spoken words. Use all senses to

communicate, including touch, smell, sight, hearing and taste.

The Alzheimer's patient, like the rest of us, wants to feel that he is succeeding. Yet life is increasingly difficult for him because of the number of failures that he experiences. Try to enter the patient's sense of reality and validate her emotions. To avoid conflict try not to say "no", but instead change behavior indirectly rather than directly. Announce or instruct rather than question. For example, say "please sit down" rather than "do you want to sit down?" Conflict situations that turn into angry or agitated outbursts by the patient usually last only about fifteen minutes.

Humor, a gentle touch, or other forms of reassurance can help to facilitate communication and understanding with Alzheimer's patients and their families.

III. DELIRIUM

Delirium is a state of disorganized thinking, wandering attention and often incoherent speech. A delirious state can also bring with it abnormal perceptions, even hallucinations, agitation, and severe mood swings. Delirium usually comes on rapidly and lasts for a short time, commonly from a week up to a month.

Causes

Delirium can result from infection, metabolic disorder, some kidney disease, thiamin deficiency, withdrawal from alcohol and/or other drugs, and some seizures or severe head injuries. Many prescription and over-the-counter medications can cause delirium, so a complete medication history is important in determining both cause and treatment.

Delirium is often a complication of dementia but is not the same as dementia, even though both may share some symptoms such as memory impairment and disorientation. Delirium tends to have a more rapid onset and fluctuating course than dementia, as well as other symptoms listed below. Delirium and dementia can exist together, but the delirium needs to be cleared up before any coherent diagnosis of other illness can take place. (9)

Signs and Symptoms

Common signs and symptoms of delirium include:

* Rapid onset.
* Fluctuating course.
* Short duration.

* Rapid emotional changes. For example, the patient can experience fear, agitation, euphoria, depression, apathy in a short period of time.
* Restlessness.
* Perceptual disturbances. For example, hallucinations, vivid dreams, nightmares.
* Cannot focus attention.
* Misinterpret external stimuli. For example, mistake a cat meowing for a woman screaming.
* Sleep disturbances - cannot sleep, cannot stay awake.

Possible Treatment Interventions
For elders with delirium it is important to:

1. Look for physical causes such as infection, thiamin deficiency, metabolic disturbances.
2. Treat the underlying physical disorder.
3. Watch for effects of medication, some of which may not have been reported by the patient.
4. Protect from injuries that can cause broken bones in frail elders. Falling out of bed and thrashing around are common in delirious states.
5. Take care to diagnose any other disease after the delirium has diminished.
6. Do supportive work with the elder to minimize embarrassment about the delirium, emphasizing delirium as a response to underlying physical causes.
7. Educate and support both patient and caregivers about delirium in order to prevent problems from reoccurring and to help the person get assistance as quickly as possible.

IV. ANXIETY

Anxiety is very common among older people. Situational anxiety may accompany any number of life transitions as well as be a response to depression or dementia. Anxiety about death and the meaning of one's life may reflect in some way the developmental tasks of older adulthood, including making sense of one's life and dealing in some way with death.

Elders may also experience more pathological anxiety, including extreme fear, panic attacks, and phobias. This anxiety can cause periods of dizziness, loss of concentration, impaired memory, and sleep difficulties. (10)

Possilbe Treatment Interventions
Accurate diagnosis is critical in order to separate out this form of anxiety from depression or dementia. Treatment can vary and could include medication, supportive work, behavioral therapy, and environmental manipulation. Care must be taken because of the addictive qualities of some anti-anxiety medications such as valium, serax, and xanax.

V. PSYCHOSES

Most types of psychoses experienced by elders also occur in younger people, but the most common psychoses in the elderly are schizophrenia, late life delusional disorder, and some symptoms of dementia. It is possible that about 5% of the over 65 population have some variation of psychosis. Psychotic patients have a high mortality rate, in part due to the violence and high suicide rate associated with such disorders. (11)

Schizophrenia affects about 1% of people over the age of 65. Most elders who have schizophrenia, about 90%, developed it before the age of 45 and grow old with the disease. These older individuals may do well if they have received effective medication and psychosocial support throughout the course of their illness. Their symptoms may even lessen, and remissions are known to occur. People who do not receive adequate care tend to deteriorate. (12)

Schizophrenia developed after the age of 45 fluctuates widely and may even constitute a different subset of the illness. This schizophrenia is more of a paranoid type. Older women are at greater risk than older men.(13) Persecutory delusions are often prominent in this disorder together with auditory hallucinations.(14)

Late Life Delusional Disorder (late paraphrenia) also affects older people and involves a non-bizarre paranoid delusional system, with or without hallucinations. This disorder does not include cognitive impairment and may not involve any other psychiatric illness. Careful diagnosis is important in order to help patient and family cope with a host of possible difficulties including housing problems and psychiatric emergencies.

Possible Treatment Interventions
When working with elders with psychotic disorders keep in mind the following considerations:

1. Consider how medication and other treatment for co-existing medical conditions affect treatment for the psychosis.
2. Other psychiatric disorders such as dementia and depression may co-exist with the psychosis and may need to be treated concurrently.
3. The patient may be self-medicating with alcohol and/or medications. Make sure to get a medication history including

over-the-counter medications, and educate patient and family about safe medication use.
4. The patient could be alcoholic and/or abusing medication or other drugs. Make sure to diagnose accurately and encourage alcoholism treatment, including detoxification if necessary.
5. If the patient has a chronic psychotic disorder it is important to periodically review his or her treatment regime and adjust as necessary as the person grows older. Especially consider how the psychosis may interact with other developing illness.
6. Keep in mind that psychotic disorders are very stressful and upsetting for patient and family. Offer social and psychological support as well as education to these families. Provide what may be most appropriate for families who are already dealing with other debilitating illnesses such as dementia and depression, and for whom the psychosis is yet another challenge.

VI. ALCOHOL AND OTHER DRUG ABUSE

Alcohol and other drug abuse, including medication abuse, is widespread among the over 65 population. Many elders overuse as a part of self-care, and others are overprescribed mood-altering medication by their personal physicians or as residents in nursing homes or other residential care settings. While most estimates place older alcoholics as between 2% and 10% of the over-60 population, the widespread use of tranquilizers, sleeping pills, pain killers, and other medications often mixed with alcohol makes more elders at risk for both drug dependency and addiction. In addition, changes in metabolic rate as the body ages can create even greater adverse reactions to alcohol and medications.

Alcoholism is a progressive, treatable but permanent disease requiring specialized treatment which includes sobriety. Alcoholism can be defined as drinking that causes problems in the person's life, health and family. It is often excessive, and may result in behavior changes. Alcoholism is often the cause of many other problems and usually needs to be addressed before other medical problems can be effectively treated.(15) Most older alcoholics began drinking alcoholically when they were younger and drink into old age, but others, perhaps up to one-third, become alcoholic later in life.

Medication abuse often stems from overreliance on tranquilizers, pain killers, sleeping pills, or amphetamines. People may become inadvertently dependent on these medications as they use more and more to achieve the same effect. Many older people also use alcohol and medications

interchangeably or together, which requires careful assessment and detoxification.

Signs and symptoms of substance abuse
Look for patterns of symptoms and note that underreporting and denial of problems is common because drug and alcohol dependency remains a stigma in this country. Some common signs to watch for include:

- Smell of alcohol on the person.
- Slurred or repetitive speech.
- Periods of dizziness.
- Periods of memory loss, called blackouts, while the person is drinking.
- Neglect of personal hygiene or appearance.
- Secretiveness about drinking or denial of drinking.
- Person seeks multiple prescriptions.
- Trouble sleeping, disturbance in sleep cycles.
- Forgetfulness.
- Difficulty managing daily routine.
- Trouble, perhaps unexplained, with: money, landlady, relatives, living situation, friends, caregivers.
- Liver or gastrointestinal problems.
- Family members report drinking or drug use.
- Social isolation.
- Unexplained injuries, bruises or falls.
- Family history of alcoholism or other drug abuse.

Note: Since alcohol and drug abuse problems can run in families, perhaps drinking and drug use by family members may put the elder at risk for abuse, neglect or financial exploitation. Look for signs of elder abuse and neglect. See Appendix for information on elder abuse.

Possible Treatment Interventions
Older people with alcohol and other drug problems can respond well to treatment. Use the following steps to help the older person get help.

Step One Identify the problem. Take a careful history and ask directly about the alcohol and other drug abuse. Alcoholics especially want to deny that they have a problem with alcohol, in part due to societal ambivalence about drinking and drunkenness, and also a fear of giving up their own drinking. Work through this denial by openly discussing your concerns in a nonjudgmental way. Point out in concrete detail how the drinking or drug use has adversely affected their lives. Medication misuse can be handled the same way, perhaps by closely relating the adverse effects of medication overuse to physical health and lifestyle.

Step Two Identify co-existing medical and psychiatric problems which may complicate treatment or perhaps seem to be preventing the person from recovering. For example, depression can result in apathy and inability to reach out for help.

Step Three Educate about alcohol and other drug use. Approach the alcoholism or medication abuse as an illness that can be overcome. Explain the physiological effects and hold out hope for the future. Share your own concern with the person. The use of pamphlets or other informational literature may be helpful in achieving an objective discussion about the dependency.

Step Four Refer to treatment. Older chronic alcoholics may have been through detox many times, but relapse is part of the illness and many elders do recover. Other older people who are dependent on medication or have not been alcoholic very long may respond well to supportive, educational groups or individual supportive work. Alcoholics Anonymous is a very effective treatment and should be encouraged, but some elders may not be able to attend AA meetings because of physical barriers or handicaps. In these cases telephone counseling when needed or Alcoholics Anonymous literature may prove useful.

Step Five Involve family members when appropriate. Alcohol and other drug dependency is often termed a family disease because it affects all who are involved with the alcoholic. Enlist the aid of family members to help the older person get to treatment, but also help family members see that they too may be affected by the drug use and may want help themselves. Organizations like Al-Anon are available to friends and family who want to talk about the stresses of living with drug and alcohol dependency.

Step Six Follow-up. Relapse is part of the disease. Continue to encourage treatment in the form of sobriety. Accept no excuses. Watch for the effects of other co-existing psychiatric and health problems which may be adversely affecting a positive outcome.

Note: Teach people how to use medication wisely to avoid future complications. Offer education and support through the many organizations available to help. Discuss alternatives to drug and alcohol use and encourage involvement in social activities and organizations.

SECTION FIVE: MENTAL HEALTH TREATMENT OPTIONS FOR ELDERS AT HOME, IN THE COMMUNITY, IN THE HOSPITAL

Programs need to work together to ensure optimal health and well-being for Massachusetts elderly. A coordinated effort of networking and effective referrals will help to facilitate this process.

Mental Health Services
When an older person needs a referral to a mental health service, whether that service is at home, in a community-based program, or in a residential or in-patient setting, make sure that the service is sensitive to the needs and concerns of elders and their families.

Mental health services for elders include the broad range of services available in Massachusetts for mental health needs. Such programs include emergency psychiatric and assessment services, outpatient counseling (individual, family and group), medication services, home visiting, case management, and in-patient hospital services as well as residential treatment when necessary. Managed care and health maintenance organizations are currently identifying elders as a growing population of health care consumers and are beginning to provide specialized services to this targeted group.

Consider the following questions when making a referral for mental health services: It may also be useful to review Section Three of this manual.

1. Are program staff trained in gero-psychiatric issues?
2. Do staff have experience in geriatric medicine or can easily access someone who is?
3. Are there other older consumers who participate in the program?
4. Is the program already connected and working with other programs that serve elders?
5. Do staff people seem aware of, interested in and sensitive to elder issues?
6. Is the program prepared to deal with a medical emergency (such as stroke, heart attack) that might strike an older person? Could the program quickly access emergency services?
7. Is the program flexible enough to adjust services if the older person changes in health or mental health status?
8. Can the program provide support for such disabilities as hearing and vision impairment?
9. Does the program provide help or support to families of elders such as caregivers who may be elderly themselves?
10. Do you as a staff person feel personally comfortable referring an older person to this program? For example, would you send your mother there if she needed services?

Elder Services

Massachusetts is fortunate to have a broad and comprehensive system of in-home social support services for low-income frail elders. These are mostly organized through the Executive Office of Elder Affairs (EOEA), which includes the 27 non-profit Home Care Corporations and also local councils on aging/senior centers. Every community in Massachusetts has access to information about services for elders who need extra help to continue living in their homes.

The Home Care Corporations (often called Home Cares) provide case management and social support services for low-income frail elders who live at home. Case managers assess what elders need and coordinate a variety of in-home, primarily social support services such as personal care services, homemaking services, meals on wheels, transportation, and telephone support. Case managers visit elders in their homes to stay current about an elder's functional status and needs, and keep in touch with in-home care providers. Home Cares also provide information on social and volunteer opportunities for elders. Support for families in the form of respite care is also sometimes available.

Local Councils on Aging provide social and community involvement and support through senior centers, which offer lunch programs, social groups, health screening, clubs, activities, trips and other social events. Most senior centers also provide some social services for elders. These usually consist of referral services and possibly individual, group or family counseling as well .For a listing of local senior centers contact the Massachusetts Executive Office of Elder Affairs, listed in Appendix B., Resources.

EOEA also funds services for elders who are physically or emotionally abused, neglected, or financially exploited. The Elder Protective Services hotline is available 24 hours a day. Each Home Care has an elder protective services program which investigates reports of possible abuse and works with the elder and family to provide the services needed to end the abuse. See Appendix B. for more information.

Adult day health programs provide support and care for elders who live at home but cannot stay home alone. Older adults spend time during the day at these centers participating in health promotion and social activities. Support is also offered to family members who are providing the help that enables their older relatives to continue living at home.

Nursing homes provide residential and health-related care for elders. Nursing homes range in size from the small, family-run structures to larger institutions that are similar to small hospitals. Nursing homes vary in their ability to

provide comprehensive services for elders. When considering placement it is important to consider staff training, support programs for families, physical accommodations, and the willingness of the nursing home to work with other organizations such as community-based intergenerational programs.

Contact the Massachusetts Executive Office of Elder Affairs, listed in Appendix B., Resources, for information about local elder services and programs.

Other Elder Services

Many other organizations also provide support, social involvement, and sometimes counseling for elders and their families. Religious organizations like churches and synagogues may have outreach programs to older members. YWCAs and YMCAs may have clubs and programs for elders. Retirement groups, civic organizations, volunteer organizations, libraries and other community based programs may provide social involvement for elders as they recover from mental illness.

When making a referral for an elder with a mental health problem to an elder services program, it is helpful to consider the following questions:

1. Does the program accept people with mental health problems? If so, what kind? For example, might the program do well with depressed elders but have difficulty handling alcohol and other drug problems?
2. What has been the program's experience with psychiatric difficulties?
3. Is there a designated staff person who has handled such referrals?
4. Is there a method or procedure for following up the referral?
5. Are there mechanisms in place for the elder services program to handle possible emergencies, especially psychiatric emergencies?
6. How does the program handle alcohol and other drug problems? For example, what would happen if a sober older person were to start drinking again?
7. Is there support for families members, including elder caregivers themselves, for helping their family member in the community?
8. Do the staff and organization seem comfortable with mental health issues? Do you feel comfortable referring the person to this organization?

Elder Advocacy

Elder advocacy groups like the Massachusetts Association of Older Americans, the Massachusetts Senior Action Council, Older Women's League and The American Association of Retired Persons (AARP) provide opportunities for working on social and political issues of special interest to elders. Organizations like the Alzheimer's Association and the Arthritis Foundation offer opportunities for older people to become involved in issues that promote health through education and advocacy.

Involvement in elder advocacy may be helpful for the older person concerned, or can be especially useful for family members who want to do something beyond the direct caregiving and take their experience and concern into the broader social arena.

Final Suggestions for Working with Older People Who Have Mental Health Problems

- Take into consideration the whole person: medical, emotional, family context, the aging sense of self.
- Assess for medical problems first.
- See the older person in the context of a long life lived.
- Be a patient communicator.
- Pay the elder the respect due to a person who is a survivor.
- Have a sense of humor.
- Remember that we are all aging, and with any luck will be old some day.

CLINICAL PRACTICE GUIDELINES FOR WORKING WITH OLDER PEOPLE WHO EXPERIENCE MENTAL HEALTH PROBLEMS

The following clinical practice guidelines represent the minimum requirements that each staff person should receive.

Guideline One: Understand aging.
1. Each staff person should have a clear understanding of the components of aging, including the biological, functional and social changes that elders may experience.
2. The strengths of elders should be supported and encouraged with the aim of achieving a healthy aging process within the family and community.

Guideline Two: Increasing access to treatment.
1. Services for older people should be as accessible and user-friendly as possible.
2. Institutional and internalized ageism needs to be addressed for both service providers and elders alike in order to overcome attitudinal barriers that discourage older people from receiving appropriate help.
3. Physical, social, and cultural barriers need to be identified and overcome so that elders will feel comfortable utilizing mental health services.

Guideline Three: Effective mental health assessment for older people.
1. Develop and implement ways to effectively assess for mental illness in the older population.
2. Have available effective assessment tools that will cover medical, psychosocial, and psychiatric issues.
3. Use methods that clarify the need for, or the shape of, further assessment for the older person.

Guideline Four: Useful working knowledge of the most common diagnostic categories for older people.
1. Have a clear understanding of the most common disorders confronting older people and how these disorders specifically affect elders.
2. Include the categories of depression, dementia including Alzheimer's Disease, delirium, anxiety, psychoses, and alcohol and other drug problems.

Guideline Five: Working with elder networks and mental health systems.
1. Gain a working knowledge of the structure and variety of elder services in Massachusetts and how they can be effectively utilized to serve elders with mental health needs.
2. Network with elder services and mental health services to provide the best possible care for the older population that each staff person serves.

NOTES

1. Margaret Gatz and Sanford Finkel, "Education and Training of Mental Health Service Providers." p. 283 in *Emerging Issues in Mental Health and Aging*, M. Gatz, Ed. Washington, DC: American Psychological Association, 1995.
2. See Martin Bloom, *Primary Prevention Practices*. Thousand Oaks, CA: Sage Pubs., 1996 for information on resiliency.
3. National Institute of Mental Health Consensus Development Conference Statement, *Differential Diagnosis of Dementing Diseases*, Washington, DC: Author, Vol 6, No.11, July 6-8, 1987.
4. Joanne Koenig-Coste, *Care for People with Alzheimer's Disease*. Cambridge, MA: Alzheimer's Disease and Related Disorders Association of Eastern Massachusetts, Inc., 1992, p.27-28.
5. *Alzheimer's Association Newsletter*. Vol. 13, No. 3, Cambridge, MA: Alzheimer's Association and Related Disorders Association of Eastern Massachusetts, Inc., Autumn 1995, p.3.
6. Koenig-Coste, p. 12.
7. *Alzheimer's Association Newsletter*. p. 14.
8. Koenig-Coste, *Communication Handout*. p. CH-1.
9. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Health Disorders* (4th ed.). Washington, DC: 1994, p.126.
10. Lon S. Schneider, "Efficacy of Clinical Treatment for Mental Disorders Among Older Persons." p. 51 in *Emerging Issues in Mental Health and Aging*, M. Gatz, Ed., Washington, DC: American Psychological Association, 1995.
11. Dill V. Jeste, David Naimark, Maureen C. Halpain, and Laurie A. Lindamer, "Strengths and Limitations of Research on Late-Life Psychoses." pp. 75-76 in *Emerging Issues in Mental Health and Aging*, M. Gatz, Ed.
12. Schneider, p. 80.
13. Schneider, p. 79.
14. Schneider, p. 49.
15. Jeanne Martin and Anita Shipman, *Passing It On: Practical Information on Medications, Tobacco, Alcohol, Intervention and Stress*. Cambridge, MA: Mount Auburn Hospital, 1995.

APPENDICES

The Appendices contains additional information and resources to support the content presented in the main body of this curriculum. Included are:

A. Training ideas for trainers. These are organized by the sections presented in the curriculum. Case vignettes are included to accompany training ideas.

B. Resource list of agencies and organizations for education, advocacy and treatment.

C. List of selected readings.

D. Articles and information that provide additional background information for trainers and staff.

APPENDIX A. TRAINING IDEAS

Training Ideas for Section One: Aging

1. Ask participants to describe an older person they know who they think is aging well. They could do this in pairs, in small groups, or individually. What is it about the older person that makes him or her seem to be aging well? Ask people to share some or their observations. As people talk, list out some of the qualities described. Ask participants to consider the following questions: Are these the qualities we usually think of when we think of older people? How are these similar to, and different from, qualities in younger people? What qualities would participants add to the list? Do participants agree with everything on the list? Are there cultural or ethnic differences that are reflected in the qualities listed? How does this list inform our assumptions about what growing old in America is like?

Refer to the list of factors that promote positive or difficult adjustment to old age (Section One). Were these covered in the discussion? Add any to the list and discuss them as well.

2. Ask participants to either describe themselves or draw a picture of themselves as they would like to be at the age of seventy years old. Include a place or setting, perhaps an activity or interest, people, animals, and things around them. Have people share their descriptions. What do these descriptions say about what we want to be like as older people? Are there any surprises for people? Was this picture difficult to do for some people?

Ask people to describe themselves as they would like to be at the age of eighty-five. They could do this verbally or draw another picture. How might this differ from their pictures of themselves at seventy? Would the picture at eighty-five be harder to draw?

3. Write out the statement, *We age as we live.* Ask participants to respond to this statement. What does it mean? What might it mean for the work that they do? Is this true for older people with mental health problems? Do they think that personality changes significantly as we age? Why or why not? Why does the culture often assume this is true?

4. Using the information provided in Section One, discuss the biological, cognitive, and functional changes associated with aging.

5. Select from the following questions to add or clarify the discussion:

What is the fastest growing age group in the United States today? A: The over-85 age group.

Memory loss is a natural part of old age.
A. Only up to a point. Memory for names and places may be reduced as well as the ability to retrieve memory as rapidly but longer term memory normally stays intact.

As people grow older they tend to lose interest in sex.
A. Not true. Older people can retain a healthy and active sex life.

It is natural for older people to become confused and even disoriented.
A. False. Check for medication interactions and misuse or other problems if an older person is disoriented or confused.

Osteoporosis, which strikes older women, can be prevented.
A. True and false. Yes, osteoporosis can be slowed down and perhaps prevented through a combination of adequate calcium intake, exercise, and vitamin D. Men as well as women can develop osteoporosis.

Arthritis can be prevented.
A. We don't know very much yet about how to prevent the many forms of arthritis. Arthritis can leave a person, young or old, in pain, tired, and sometimes depressed as part of the illness. However, much can be done to manage arthritis.

Hearing loss can make older people appear confused and disoriented, when in fact they are not.
True. Many older people compensate for not being able to hear by guessing at questions and trying to answer accurately. This can make them seem to either not understand or to distort what was said.

Training Ideas for Section Two: Working with Older People Experiencing Mental Health Problems

1. Lead a discussion about what people have already seen in terms of how "user-friendly" their program is for elders, and in what ways they consider older people to be similar and also different from their younger counterparts with the same or similar problems.

2. Have participants walk through their program, and think about how an older person would react to the physical setting. Would the older person be able to get around comfortably? Are there physical barriers that might make the setting difficult in which to maneuver?

3. Review each suggestion presented in the curriculum for how to make a program more user-friendly for elders and their families. Ask staff to consider how these suggestions might apply to their program, and to contribute any other additional suggestions.

4. Ageism is a pervasive problem that could be addressed in some depth. The following is a list of ideas to help staff become more aware of the ageism in our society and how they can learn to change both internalized and cultural ageism.

- Brainstorm to the word "old." Many of these associations may be negative. Point out that as a society we have many negative stereotypes of aging. What ways can we replace these stereotypes with more positive ideas of aging?

- Hold a discussion about why we often tend to view old age in negative terms. What is it about our society that makes it so youth-oriented? How does this affect us, both old and young?

- Bring in an assortment of birthday cards about growing old. Pass them around and ask staff to comment on what kind of messages about aging these cards portray. Discuss what societal messages these cards communicate about growing old in America.

- Hold a discussion about media images. How are older people portrayed on television and in the movies? What roles do older actors play?

- Ask staff to think about how older people were viewed in their own families or cultures. Can staff think about cultural differences regarding aging? Have staff had differing personal experiences in how they view older people? How does this impact their work with older people?

- Many other societies award more status and respect to old people. For this reason, some older immigrants may encounter ageism for the first time in the United States. Ask staff how this might impact an immigrant elder or family member who is in need of mental health services.

- Hold a discussion about why older people are so often talked to as if they were small children. Why does this happen? Are there ways that staff can counteract this tendency in our culture?

- Ask staff to think about what *internalized ageism* means, and how it can reduce an older person's efforts to get help and make change. How might staff help elders change or at least soften some of their harsh negative feelings about themselves?

* Encourage staff to think about ways they can identify ageism when it occurs and how they can take steps to reduce ageism and its effects in their everyday lives. Stress that we are all adversely affected by ageism, young and old alike.

Training Ideas for Section Three: Sudden Changes in Mental Status: Guidelines for an Effective Assessment

1. Ask staff to describe the last time they assessed an older person for mental illness. How did they do this? What was the procedure? Did they do anything differently than they would have done for a younger person?

2. Ask staff to list the essential components of an effective assessment. Use the curriculum to expand on these components.

3. Review each assessment component and make sure that your program has a clear and definable way of carrying out each step in an assessment.

4. Review the assessment tools used in your program. How do these tools expand upon and support the assessment you are doing for elders with mental health problems? For example, do the assessment tools take into consideration medication use by elders? Do they include possible medical problems that can mask as mental illness?

5. Discuss how staff can especially take into consideration medications that elders may be taking, and how these medications may impact a possible diagnosis.

6. Share suggestions for how to best ask particular questions that might be difficult and how to elicit the information needed for an accurate assessment.

7. Review the section, *Special Considerations of Medical Conditions*. Make sure everyone is clear about each factor, has necessary background information about each, and can determine how these factors contribute to an effective assessment.

8. Using case examples provided by staff, discuss how easily a misdiagnosis can take place and how to ensure an accurate assessment.

9. List the appropriate referral sources for further assessment, and make sure each staff person knows how to proceed if further assessment is needed.

Training Ideas for Section Four: Common Mental Health Diagnostic Categories

1. Review each diagnostic category with staff, referring to the content presented in the curriculum. Use the corresponding informational handouts in the Appendix D. if they seem appropriate to your program.

2. Review the signs and symptoms for each category. Help staff to consider how these signs and symptoms might present themselves in an older person. It may be helpful to differentiate between the over-65 and the over-85 age groups.

3. Consider the planning procedures presented in the curriculum and ask staff to apply these suggestions to any experiences they have had with the elders they serve. Do these interventions work? Apply their ideas to the case vignettes provided in Appendix A.

4. Discuss the issue of dual diagnosis, for example, alcohol addiction and depression, or medication abuse and dementia. Using case material from staff experience or the vignettes provided in the Appendix A., consider how to approach an elder who has two or more illnesses.

5. Describe how medication misuse or overuse can affect intervention and treatment. Using the information in the Appendix, review with staff how to educate patients and family members about proper use of medications.

6. Ask staff to describe ways they can help elders and family members recover from these mental health problems and prevent future problems from occurring. Brainstorm a list of strategies that staff can use to promote health and well-being.

7. Invite speakers from the following organizations to help educate staff. Refer to the resource list in Appendix B. for addresses and phone numbers.

- Speaker from the Alzheimer's Association to talk about dementia, support for patients and family, and how to reduce the destructive effects of the disease.

- Speaker from an alcohol and drug treatment program to discuss how to work with older addicted adults and the possibilities for recovery.

- An older alcoholic from Alcoholics Anonymous who can talk about his or her recovery process and how AA works.

- Worker from Elder Protective Services who can talk about how elder abuse and neglect can exacerbate mental health problems.

* Speaker from The Boston Society for Gerontologic Psychiatry, Inc. to discuss how depression, psychosis, and other psychiatric illness affect older people.

* Speaker from The Samaritans to talk about how to prevent both completed and attempted suicide among the elderly in Massachusetts.

* Speaker from the Massachusetts Department of Public Health, Elder Health Unit, to discuss general health promotion issues as well as medication misuse, injury prevention and urinary incontinence, all of which affect elders' ability to maintain health and well-being.

Training Ideas for Section Five: Mental Health Treatment Options for Elders at Home, in the Community, in the Hospital

1. Using the content presented in the curriculum, describe the range of services available for low-income elders who live at home.

2. Invite a representative from the Home Care Corporation that covers your communities to describe the services available and how they work. Have copies of the Home Care's newsletter and other relevant information that describe available services. Include the Elder Protective Services component in this presentation.

3. Identify the other programs that serve older people in your region or community. Include the range of traditional and less traditional services described in the curriculum. Make a list of these services and develop a file that contains program descriptions and literature for referral

4. Consider how to network with these elder services groups in your program's community through participation in community-wide events, task forces, or planning committees.

5. Keep an updated referral list of all programs that you refer to with current staff names and phone numbers so that staff will know who to contact. Use the questions listed in Section Five to assess how sensitive these programs are both to elder needs and mental health issues.

6. Review the following case vignettes and encourage staff to think about how they might make effective referrals for the elders described and their family members.

Case Vignettes

Depression

Mrs. G.,72 years old, recently retired from her job as an office manager in her brother's law firm. She reported to her primary care provider at a regularly scheduled visit that she had been feeling extremely lethargic for the past three months. She also said she was not sleeping well, and upon examination was found to have lost ten pounds since her visit one year before. After undergoing some diagnostic tests which proved negative, Mrs. G. was told by her physician that nothing was physically wrong with her and that what she was experiencing were merely signs and symptoms of aging.

Mrs. G. continued to feel unlike her usual self. She found that even reading, a pastime she usually enjoyed, did not interest her, and she began to spend more and more of each day in bed. Finally a concerned friend suggested she see a counselor at her local mental health center. Although she never had thought of herself as needing psychiatric services, she hated feeling so badly and was ready to try anything to feel better. After meeting with a social worker several times she began to understand that her retirement was a major life event which she had minimized and for which she had not planned. She realized that she was experiencing intense feelings of worthlessness because so much of her identity had been wrapped up in her work. At the social worker's suggestion she joined a group for women experiencing loss and change.

Dual Diagnosis

Mr. B., an 85 year old retired firefighter, had always lived his life "on the edge." Even after retiring he still chased fires. Known as a "guy who liked his beer," he began drinking throughout the day when he no longer had to report for work. His family became alarmed after they discovered he had spent all of his and his wife's savings on an antique fire engine which he drove home with the siren blaring.

Unable to persuade him that he needed help, Mr. B.'s sons called the police, who brought him to the designated psychiatric emergency service for his town. There, an evaluation of Mr. B.'s cognition, mental status and physical health was performed to determine the possible existence of a substance abuse problem, affective illness, and dementia. Based on the results of the evaluation, Mr. B. was referred to an inpatient unit specializing in dual diagnosis.

Dementia

Mrs. M., a 73 year old woman who lived alone, was found by a neighbor wandering around her street. When questioned, she said she could not remember how to get back from the corner store to her apartment in the neighborhood. Since this was not the first time this incident had occurred, the neighbor

called Mrs. M.'s daughter, who lived out of state, to express her concern about Mrs. M.'s confusion. The daughter contacted her local Alzheimer's Association which provided her with information and suggested a dementia work-up at a facility specializing in this type of evaluation.

Following the evaluation, which indicated that Mrs. M. had early signs of Alzheimer's Disease, her daughter contacted the Home Care Corporation serving her mother's community. A case manager came to Mrs. M.'s home to assess her needs. Based on this assessment, the case manager developed and implemented a service plan to meet Mrs. M.'s needs. This plan included Mrs. M.'s attending an adult day health program three days a week, a grocery shopping service, and a homemaker once a week. A telephone reassurance volunteer called her on the days she did not attend the adult day health program to make sure she was safe. The case manager remained aware of Mrs. M.'s status and changed her service plan as her needs increased. Mrs. M.'s daughter kept in regular touch with the case manager and her mother, who expressed a desire to remain in her home as long as possible.

Delusional Disorder

Mr. B., a 66 year old homeless man, appeared to be well-groomed and articulate, so he was able to find housing in the city. However, within a few weeks of finding a new room, he would accuse the landlord and other tenants of plotting to kill him, and caused commotion by yelling all night for them to stay away. After another period of homelessness he was again placed in elderly public housing where the same kind of behavior occurred and Mr. B. was once again evicted. He was hospitalized at a DMH facility, where he did very well on the structured life and medication. After discharge Mr. B. stopped taking his medication and again manifested the same behavior of yelling and threatening people. Due to this renewed behavior the police brought him back to the hospital.

Reversible Dementia

Mrs. N., 90, had been functioning very well living alone in her own home of fifty years. Although she had no social services her daughter called every day and did her grocery shopping for her. However, she began to report feeling dizzy, fell several times, and seemed disoriented and forgetful. Assuming she had Alzheimer's Disease, her daughter decided to look for a nursing home for her. However, after another fall her mother was admitted to a local teaching hospital where she was given a number of tests for Alzheimer's Disease. These proved to be negative. Instead Mrs. N. was found to be suffering from severe hypothyroidism. She returned to her home with VNA medication monitoring, where she eventually recovered her former level of independent self-care.

APPENDIX B. RESOURCES

Administration on Aging
330 Independence Avenue, SW Room 461
Washington, D.C. 20201
202-401-4634

Alcoholics Anonymous
368 Congress Street
Boston, MA 02210
617-426-4807
telephone helplines: 617-426-9444, 508-752-9000, 413-532-2111

Al-Anon Family Groups
639 Granite Street
Braintree, MA 02169
617-843-5300, 508-791-3431, 413-499-8268

Alliance for the Mentally Ill
of Massachusetts
295 Devonshire
Boston, MA 02110
617-426-2299

Alzheimer's Association of Eastern Massachusetts
One Kendall Square
Building 200
Cambridge, MA 02139
617-494-5150
Education, referral, advocacy
Contact also for other Massachusetts locations

Alzheimer's Disease Education and Referral Center
P.O. Box 8250
Silver Springs, MD 20907-8250
800-438-4380

American Association for Geriatric Psychiatry
Sanford I. Finkel, MD
Director, Gero-Psychiatric Services
Northwestern Memorial Hospital
446 East Ontario Street, Suite 840
Chicago, Illinois 60611

American Association of Retired Persons,
Massachusetts State Office
116 Huntington Avenue
Boston, MA 02116
617-723-7600 TTY 617-375-0404
Advocacy, education, materials

Depression Awareness Recognition &
Treatment (D/ART) Program, NIMH

5600 Fishers Lane
Room 10-85
Rockville, MD 20658
800-421-4211

Massachusetts Association of Older Americans
110 Arlington Street
Boston, MA 02116
617-426-0804
Advocacy, education

The Massachusetts Board of Registration in Pharmacy
100 Cambridge Street
Boston, MA 02202
617-727-9953

The Massachusetts Department of Public Health
Division of Food and Drugs
305 South Street
Jamaica Plain, MA 02130
617-727-2670

The Massachusetts Department of Public Health
Elder Health Programs
250 Washington Street - 4th Floor
Boston, MA 02108
617-624-5405 TTY 617-624-5992
Contact for prevention, education and referral
Contact for listing of the 10 regional prevention centers

The Massachusetts Drug and Alcohol Hotline
800-327-5050 (24 hours)
617-445-1500 TTY 617-354-0996

Mass Home Care
800-AGE-INFO
Information on financial Assistance

The Massachusetts Executive Office of Elder Affairs
One Ashburton Place
Boston, MA 02108
617-727-7750
Contact for: Elder Protective Services
Information on Home Care Corporations, Senior Centers and Councils on Aging

The Massachusetts Poison Center
800-682-9211 TTY 617-735-6087

National Council on Aging
409 Third Street, SW, 2nd Floor
Washington, DC 20024
202-479-1200

National Institute of Alcohol and Alcoholism
Gayle Boyd, Ph.D.
Program Director for Research on Youth and Aging
6000 Executive Boulevard, Room 505
Rockville, MD 20892
301-443-3885

National Institute of Mental Health
Barry Lebowitz, Ph.D.
Chief of the Mental Health Disorders of the Aging
Research Branch
5600 Fishers Lane
Room 18-105, Parklawn Building
Rockville, MD 20857
301-443-4513 TTY 301-443-8431

National Institute on Aging
Stanley Slater, MD
Deputy Associate Director for Geriatrics
Geriatrics Program
NIA/NIHAU
7201 Wisconsin Avenue
Bethesda, MD 20672
301-496-4000 TTY 800-877-8339

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
800-969-6642 TTY 800-433-5957

The Samaritans
Befrienders International
Samaritans USA
Call 411 information for
local office and
telephone.
Suicide hotline, prevention.
Boston 617-247-0220

APPENDIX C. SELECTED READINGS

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APPENDIX D. ADDITIONAL INFORMATION

Included in Appendix D. are the following information sheets, for use with Appendix A. Training Ideas, and also to generally augment the information provided in the curriculum.

Fact Sheet: Depression in the Elderly

Talking with a Deaf or Hard of Hearing Person

Signs and Symptoms of Hearing Loss

Using Medications Wisely: Guidelines to Follow

National Institute of Mental Health

Fact Sheet:

Depression in the Elderly

Mental Disorders of the Aging Research Branch
Barry D. Lebowitz, Ph.D., Chief

Alcohol, Drug Abuse and Mental Health Administration
Public Health Service
U.S. Department of Health and Human Services

Throughout our lifetimes, emotions play a vital role. The richness and complexity of our emotions are part of what make us distinctly human. They affect how we see and interact with our world and, at the same time, they are responsive to the events around us. Since ancient times, scientists and philosophers have tried to understand the causes of our emotions. Why, for example, should two people have distinctly different reactions to the same situation? Ancients would have said that differing emotional reactions to the same situation were the result of "humours" or bodily fluids. Today, we know that some feelings and reactions are normal and healthy parts of living; other feelings, however, may signal a problem that requires evaluation and treatment by a competent mental health professional. Depression is one of those common emotions that affects people of all ages, and sometimes requires and benefits from professional help.

What is depression?

The concept of depression has at least two very different meanings. It refers both to an often-felt normal emotion of sadness and to a diagnosable and treatable mental health problem. We know that almost everyone of every age occasionally suffers from brief experiences of "the blues" or sadness. These feelings are normal. Feelings of grief or bereavement, too, may be quite normal when a loss has occurred. However, when these feelings occur again and again, last for several weeks or months without a let-up, and interfere in an important way with everyday activities, the feelings could indicate the presence of what mental health professionals call "depressive illness," or "clinical depression."

Depressive illness can occur at any age. Studies have found that among the elderly in institutions -- long-term care and acute care facilities alike -- the prevalence of medically significant clinical depression is as high as 10-20 percent. In the community, however, clinical depression in those over 65 years of age is present in perhaps one to two percent of the population, a lower rate than found in younger populations. Yet, research also has found that over 10 percent of the elderly living in the community, while not suffering from depressive illness per

se, may be affected by important and treatable symptoms of depression associated with physical illness, life changes, or stress.

In the elderly, depressive illness can take several forms and is sometimes difficult to recognize. Depressive illness may be masked by physical complaints, be hidden by the sufferer from family and friends, or be misperceived as a normal part of aging. Yet, it is important to remember that depressive illness generally is treatable. Neither depressive illness itself nor the act of seeking treatment for the illness is indicative of a character weakness or personality flaw. Depressive illness is just that, an illness able to be treated or cured, if the prudent decision to seek treatment is made. No one need suffer needlessly from untreated severe depression.

What causes depressive illness?

While the precise mechanism through which depression occurs has not yet been discovered, usually, a number of factors -- based within the person's biology and environment -- combine to bring about depression. Each person's reaction depends on how those factors affect him or her personally. Some people have an inborn tendency toward depression. However, that doesn't mean that they are automatically going to have a depressive illness; it means only that they are more likely to have one. Depending on their personality development and life experiences, they may escape severe depression altogether. A prior history of depression, too, may make depression a more likely, but not necessarily inevitable, occurrence in older persons.

It is also not surprising that a person subjected to a continuing series of severe personal losses may develop depressive illness. Events, such as the deaths or other loss of lived ones and companions, chronic physical illnesses, unexpected or continuing financial problems, or severe changes in life-style can combine to create terrible suffering and loss of self-esteem, leading to depressive illness.

Physical illness, too, has been shown to play a role in depression of later life. Depression may accompany chronic health problems in particular. Increased physical disability may predispose a person to depression, heighten the risk of suicide, and increase the likelihood of recurrent depressive episodes.

Depressive symptoms may appear as a side-effect of the use of certain prescription and over-the-counter medications used to treat physical disorders. In particular, many elderly people being treated for age-related illnesses are given medicines that, while effective in combatting the physical problem, can affect the emotions. Certain blood pressure medications, for example, may cause depression as an immediate or long-term side-effect. When several medications are being used at the same time, the combination of the medicines can cause mood changes. Thus, it is important for physicians to know of all medications being prescribed and over-the-counter medicines being used to help either diagnose or prevent a depression that is a side-effect of medication.

Yet, despite our ability to identify factors that may increase the likelihood of depression, spontaneous depression in later life may occur for the first time with no apparent causes. Indeed, the most severe melancholic depressions (in which patients lose interest in virtually all activities of living) are prone to sudden onset.

Whatever the cause, with appropriate professional diagnosis and treatment, the feelings accompanying depressive illness may be alleviated.

Recognizing depressive illness

Depression affects a person's physical well-being, feelings, thoughts, behavior with others, and general ability to func-

tion. Depressed people demonstrate an overall loss of interest or pleasure in their usual activities and often appear sad, apathetic, and withdrawn from others. They may act tearful, agitated, angry, or irritable. They often talk of feelings of guilt, worthlessness, or hopelessness. Frequently, they exhibit loss of appetite and subsequent weight loss, have trouble sleeping, and appear tired. When symptoms such as these are not brief, or, if brief, tend to recur, professional advice should be sought.

Sometimes, depressed older persons will complain of aches and pains throughout the body or of fears of symptoms they believe are signs of severe physical illness. At times, it is difficult to figure out which symptoms are based on a physical problem and which are based on emotions. Vague complaints that have not true physical basis may be indicative of an underlying depression, a determination that can be made only by a competent treating professional.

In other cases, older persons are considered "senile" or thought to be suffering from Alzheimer's disease, when they actually are suffering from severe depression. In such cases of what physicians call "pseudodementia," memory seems to fade, complicated thinking seems difficult. They seem to have trouble with concentration. In such cases, it is important for a qualified mental health practitioner who specializes in treatment of the elderly to ensure that so-called "senility" is not a treatable, reversible depression in disguise.

On occasion, true memory loss (or dementia) may coexist with depression. In this case, treating the depression will not improve the memory deficits experienced, but such treatment will improve the patients' quality of life, enabling them to cope more successfully with their memory impairment.

The safest way to manage any of these apparent symptoms of depression is to seek professional care. Self-diagnosis, particularly in the elderly for whom depression may be a symptom of an age-specific physical disorders, is dangerous.

Seeking treatment

While depression is usually a self-limiting condition, with most patients experiencing spontaneous recovery or marked improvement, it is dangerous to take a "wait and see" approach when dealing with the elderly. Depression itself can cause physical problems in the older adult. For example, a depressed older person may lose interest in food, become malnourished, and, thus, weaken the body's resistance to disease. Because depressive illness frequently distorts judgment, a depressed person may ignore rashes, changes in stool or urine, or other signs of a physical illness in need of treatment. Moreover, the risk of suicide among the depressed elderly is significant, especially among those living alone and already physically ill. Thus, when an older person complains of being depressed or not caring, when that person evidences persistent changes in behavior, evaluation by a mental health professional is important.

Outpatient mental health evaluations can be obtained at mental health clinics or from independent mental health professional with offices in the community. Community mental health centers -- publicly-funded mental health clinics -- exist in most areas and usually maintain graduated fee schedules. Whether evaluation and treatment is sought at a clinic or from a private practitioner, it is advantageous to see an individual who is familiar with problems of the elderly. Frequently, local Area Agencies on Aging, local or county offices of mental health, and mental health professional societies can provide guidance in locat

ing high-quality professional help. Older persons seeking mental health evaluation may wish to seek a referral from their own doctor.

An evaluation for depression typically includes a determination of whether a biological condition of medications in use are implicated in the depressive symptoms in question. The older person and any accompanying concerned others will be asked about both the kind, severity, frequency, duration, and past history of depressive symptoms, and about any past or current life circumstances that may have precipitated or contributed to the current symptoms of an apparent depression.

If a finding is made that the older individual is suffering from a depressive illness, a number of specific treatments are available. The type of treatment recommended by the treating professional is made on the basis of detailed information about the nature of the depression itself, the course of the illness, the family history, and the response to previous treatment.

Research has shown that, as other age groups, the elderly often respond quickly to therapy. Some therapy methods include family members; others involve small groups; and still others involve only the depressed person and a mental health professional. Antidepressant medications frequently are prescribed by a psychiatrist or other treating physician for people with more serious depression, unless medical reasons preclude their use. Such medications often take some time to work and must be monitored carefully to avoid side-effects. However, research data attest to the efficacy of such medications in treating many cases of severe depressive illness over time when used in the hands of careful and specially qualified physicians.

Treatment outcome

Scientific studies have shown that 60-80% of depressed elderly outpatients can be treated effectively with psychotherapy and/or with antidepressant medication. The remaining patients frequently benefit from more specialized forms of psychiatric care, sometimes provided in the hospital. Some patients may need to remain on medication to prevent recurrence, a situation similar to taking medication on an ongoing basis for high blood pressure or diabetes.

Can depression occur again? Unless steps are taken to prevent recurrence, the answer is probably yes. Depression is a recurrent illness; most individuals, if followed long enough, suffer new episodes. Early relapse is associated with patients who either have had a substantial number of prior episodes or who suffer a first episode late in life. The elderly generally are at greatest risk for recurrence. That is why understanding what caused the initial depression and taking appropriate early action is so important. Depressions treated early have a better chance of successful outcome.

Moreover, a stable personal environment will decrease the risk of further depressive episodes. Close personal ties and an intact social network provide the patient with personal support and help the clinician monitor patient progress. This support may come from family and friends and may be strengthened further by social service agencies and mental health centers. The presence of sufficient services may make the difference between a life at home or in a hospital.

In sum

Depressive illness -- a medically significant disorder -- does not respect age.

Equally, effective treatment of this illness transcends the age of the patient. When depression occurs in the elderly, it should not be confused with either natural aging or with other age-specific illnesses. Depression, whether an underlying cause of a physical complaint, as a consequence of a physical disorder, or as a spontaneously occurring primary illness, can be readily diagnosed and treated by a competent mental health professional who is especially attuned to the mental health needs of the elderly. Local health and social service agencies, health professional societies, and other health care organizations can help locate appropriate professional help. With that treatment, depressive illness, in fact, can be cured.

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Rockville, MD 20857

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TALKING WITH A DEAF OR HARD OF HEARING PERSON

SUGGESTED GUIDELINES

1. Before you speak, gain the person's attention. A touch on the shoulder or arm, or a wave is usually enough.

2. Be sure the person is seated to his or her best advantage. This usually means a seat closer to the speaker or interpreter.

3. Avoid standing or sitting in front of a light source, such as a window or bright light. The shadow created on your face makes lip-reading very difficult.

4. Minimize background noise and other distraction. Hearing aids, although helpful, pick up background noise and can interfere with a person's ability to hear.

5. Do not put anything into your mouth, such as a pencil or gum, when speaking.

6. Speak directly to the person even if an interpreter is present.

7. Speak slowly and clearly. Unless asked there is no need to speak more loudly than usual.

8. Use nonverbal skills such as pantomime and body language to help clarify the discussion.

9. Keep the pace of the conversation slow, but natural. Organize the conversation around key points and try not to jump around. The person needs to know topics and subject matter in order to lip read effectively.

10. Check for clarification to make sure that communication is clear and well understood.

From: How to Communicate with a Deaf Person.
The Commonwealth of Massachusetts. Executive Office of Human Services, Massachusetts Commission for the Deaf and Hard of Hearing.

SIGNS AND SYMPTOMS OF HEARING LOSS

Consider the following signs and symptoms of possible indicators of a hearing loss.

1. Frequently misunderstanding words (*pill* for *bill*).
2. Asking people to repeat themselves.
3. Responding inappropriately to what is said.
4. Assuming that people are mumbling.
5. Speaking too loudly or too softly.
6. Difficulty understanding phone conversations.
7. Watching a person's face and mouth intently.
8. Turning head to one side to better hear what is said.
9. Straining to hear what is said.
10. Looking puzzled.
11. Not understanding what is said in groups.
12. Not attending social gatherings.
13. Turning on radio or television too loudly, or stopping listening to radio or television.
14. Defensiveness about communication difficulties.

From: Symptoms of a Hearing Loss, The Commonwealth of Massachusetts Executive Office of Human Services, Massachusetts Commission for the Deaf and Hard of Hearing.

USING MEDICATIONS SAFELY
GUIDELINES FOR OLDER PEOPLE

1. Follow all directions for storing medications, making sure they are kept at proper room temperature, etc.

2. Throw out all expired medications. Place orders for refills several days ahead of time to avoid last minute problems.

3. Take all medications exactly as directed. This includes over-the-counter medications as well as prescriptions.

4. Become aware of any unexpected side effects and report them to your physician or nurse practitioner.

5. Check with your physician or nurse practitioner before taking any additional medications. For example do not take cold remedies if you are taking other medication, unless you speak with a physician or nurse. Pharmacists too can be reliable resources of information on how medications might interact.

6. Keep a daily plan and routine for taking medications. Use a calendar, checklist, or a medication organizer to help you remember when and how many medications you take.

7. Keep medications in their original containers in order to identify them. Only take out the number you might place in an organizer for the week.

8. Use only reliable medications. Avoid false promises of quick cures. If the medication or remedy sounds too good to be true, it probably is not true.

9. Keep a list of your medications on hand for your reference. Make sure someone else has this list and can be reached for emergencies if necessary.

10. Read medication labels for ingredients. Try to avoid brands that contain alcohol, caffeine, and sugars and dyes if possible.

11. Alcohol can interfere with the positive effect of medications. Check with your physician or nurse.

12. Periodically check with your provider about your medication use, even if you are on prescription medications. Changes in body weight, metabolism and even lifestyle may call for a readjustment of medication regime.